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PARTNERS IN HEALTH UPDATE

October 2008

Working Together For Quality Health Care

Sleep Medicine added to Provider Directory

Independence Blue Cross has added Sleep Medicine as a listed specialty in the Provider Directory. The credentialing department identified the following requirements to be recognized for this specialty: board certification by the American Board of Medical Specialties and an American Board of Medical Specialties subcertification in Sleep Medicine *or* current board certification by the American Board of Sleep Medicine.

Requests for recognition of a sleep medicine specialty should be submitted through your Network Coordinator. The credentialing department will verify the sleep medicine credentials and notify you if you are approved.

For articles specific to your area of interest, look for the appropriate icon:

Professional

Facility

Ancillary

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NATIONAL PROVIDER IDENTIFIER (NPI)

Claims submitted without a valid, registered NPI will reject

NPIs must be registered with IBC

As mentioned in previous publications, claims submitted to Independence Blue Cross (IBC) without a registered NPI have been rejecting since May 23, 2008, per the Centers for Medicare & Medicaid Services mandate. NPIs may be registered online by submitting an NPI provider registration web form at *www.ibx.com/providers/npi/provider_registration.html.*

Claims submitted with invalid NPIs will reject

Each claim must pass an NPI check-digit validation to ensure that it has a valid NPI. To date, many claims are not passing this check-digit validation. The most common reasons why claims are not passing the NPI check-digit validation are:

- The wrong provider identifier is entered in an NPI field.
- The NPI is entered incorrectly.
- The number entered is not a valid NPI.

Processing of claims

For purposes of processing a claim in accordance with the reimbursement terms of your IBC provider contract, you may continue to provide your 10-digit legacy number in addition to your valid, registered NPI. The sole purpose for providing the 10-digit legacy number is to facilitate accurate claims payment — not to identify the claim for acceptance into IBC's system. Only a valid NPI will be accepted by IBC as the primary identifier on the claim.

If you need more information about NPI claims submission, please refer to the IBC "*National Provider Identifier (NPI) Toolkit: Tips for Proper Electronic and Paper Claims Submission*." The document can be found at *www.ibx.com/pdfs/providers/npi/toolkit.pdf.*

Learn more about NPIs. Our previous communications, FAQs, and additional resources, are available at *www.ibx.com/providers/npi.*

Please note: IBC will receive contracted behavioral health providers' NPI information directly from Magellan Behavioral Health, Inc., an independent company. For more information, please contact Magellan National Provider Services Center at 1-800-788-4005, or visit Magellan at www.magellanhealth.com.

BILLING

Important notice regarding timely claims filing requirements

In an effort to increase operational efficiencies and standardize policies for all providers and benefits programs, Independence Blue Cross (IBC) has reviewed the current timely claims filing requirements for claims submissions contained in current provider contracts.

Unless otherwise stated in your contract, this is to clarify that effective for dates of service on or after **December 1, 2008**, IBC will implement the following as its standard policy for timely filing of claims:

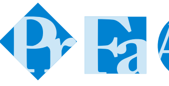
- For inpatient services, providers shall submit claims to IBC within twelve (12) months following the date of discharge for an inpatient admission.
- For all other covered services, providers shall submit claims within twelve (12) months following the date of service — e.g., outpatient services, office visits, date of medical transport, date of delivery for durable medical equipment.

In the event IBC's payment responsibility is not determined until subsequent to the date of discharge or covered services, providers must submit the claims within twelve (12) months of the determination.

Please note that claims will not be accepted for payment if submitted more than twelve (12) months from: (i) the date the covered services are rendered, or (ii) where IBC is the secondary payor, the date the primary payor has made payment or denied the claim. In accordance with the terms of your contract, members may not be billed for claims that were not accepted because they were not timely filed.

Please contact your Network Coordinator or Customer Service with any questions.

Upcoming CFID provider audits



In addition to the Corporate and Financial Investigations Department's (CFID) role in combating fraudulent practices against Independence Blue Cross, the CFID is also responsible for conducting audits of facility and professional providers, ancillary service providers, and pharmaceutical-related entities. By using sophisticated data-mining software tools, the CFID analyzes claims and compares them to member enrollment data and overall provider information. Any trends, patterns, or aberrant billing practices are selected for an in-depth audit or investigation.

Upcoming audits to investigate trends in questionable billing

Based on recent trends that have been identified in the data, the CFID would like to alert providers to some questionable billing practices that will be the focus of upcoming audits. The CFID audit team, which consists of registered nurses, medical coders, and claims experts, will be conducting audits that focus on the following areas:

- Facility provider audits:
  - DRG validation audits to assure that submitted claims are coded properly and remitted appropriately;
  - outpatient fee schedule coding audits to assure that CPT®/HCPCS codes are properly submitted to reflect the services rendered and that remittance is consistent with policy/contracts;
  - outpatient observation audits to assure that services rendered accurately match services billed;
  - outpatient critical-care audits to assure accurate coding of outpatient critical-care ER visits.
- Professional provider audits:
  - inpatient and outpatient Evaluation and Management (E&M) services audits to assure the appropriate levels are billed and paid, including consultation codes and the use of modifiers 24 and 25 with the E&M claim submissions;
  - office site of service audits to assure services receiving a site-of-service differential were rendered and billed in the office place of service;
  - colonoscopy code audits to assure correct coding and billing;
  - single- versus multiple-unit audits to assure the correct units are billed as defined for CPT codes;
  - high-dollar medications administered in physician office audits to assure the accuracy of claims billed;
  - duplicate billing audits to assure duplicate claims are denied appropriately;
  - anesthesia base code and "add-on" code audits to assure units are billed correctly.
- Ancillary provider audits:
  - high-dollar medications administered in the home setting audits to assure the accuracy of claims billed;
  - durable medical equipment audits to assure claims accurately reflect services rendered;
  - medication compounding audits to assure that necessary and appropriate compounding and billing are done only when commercially prepared mixtures are not available.

Health care fraud is a violation of state and/or federal law. An easy-to-use process exists for reporting any suspected fraud, waste, or abuse. If you are suspicious of any health care-related activity, please call our toll-free Corporate Compliance and Fraud Hotline at 1-866-282-2707, or visit *www.ibx.com/anti-fraud.* These tips can lead to audits and/or fraud investigations that can result in monetary recoveries, all of which help keep health care costs down.

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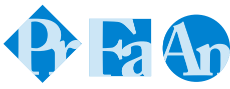
Valid NDC required on claims submitted for drugs (e.g., J codes and other drug codes)



Please be advised that a new edit to validate the National Drug Code (NDC) submitted on paper and electronic claims is forthcoming for claims submitted with an unlisted drug code. Please review the billing requirements below for your applicable provider type. Certain claims for unlisted drug codes that are not accompanied by an NDC in the format and location as described below will not be processed and will be returned to you for correction prior to processing.

For professional providers: Effective January 1, 2009, claims for all ***unlisted*** drug codes (CPT® or HCPCS) will require submission of an NDC in the format and location as described below. If the NDC is not submitted in the correct format or is missing, the claim will not be processed and will be returned to you for correction prior to processing. The complete list of unlisted codes that require the submission of an NDC is below.

For home infusion providers: Effective January 1, 2009, ***all*** drug claims (not just the unlisted CPT or HCPCS codes in the table below) will require the submission of an accompanying 11-digit NDC. This includes claims for Hemophilia Factor products that are currently submitted with specific J codes.

For institutional providers: Effective February 1, 2009, all claims for outpatient services containing the following pharmacy revenue codes, and an ***unlisted*** (CPT or HCPCS) code will require a valid NDC when submitted: 250-259, 262, 263, 331, 332, 335, 343, 344, and 631-637.

NDC billing information

Please submit the NDC number using the 5-4-2 format when billing with hyphens (e.g., 12345-1234-12). NDC numbers without hyphens (e.g., 12345678911) will also be accepted. Please *do not* include spaces, decimals, or other characters in the 11-digit string or the claim will be returned for correction prior to processing.

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Unlisted codes that will require submission of an NDC*

Code	Description
90399	Unlisted immune globulin
90749	Unlisted vaccine/toxoid
A4641	Radiopharmaceutical, diagnostic, not otherwise classified
A9150	Nonprescription drug
A9152	Single vitamin/mineral/trace element, oral, per dose, not otherwise specified
A9579	Injection, gadolinium based magnetic resonance contrast agent, not otherwise specified, per ml
A9698	Nonradioactive contrast imaging material, not otherwise classified, per study
A9699	Radiopharmaceutical, therapeutic, not otherwise classified
A9700	Supply of injectable contrast material for use in echocardiography, per study
C2698	Brachytherapy source, stranded, not otherwise specified, per source
C2699	Brachytherapy source, nonstranded, not otherwise specified, per source
C9399	Unclassified drugs or biologicals
J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg
J3490	Unclassified drugs
J3530	Nasal vaccine inhalation
J3535	Drug administered through a metered dose inhaler
J3590	Unclassified biologics
J7199	Hemophilia clotting factor, not otherwise classified
J7599	Immunosuppressive drug, NOC
J7699	NOC drugs, inhalation solution administered through DME

continued on page 5

Valid NDC required on claims submitted for drugs (continued)

J7799	NOC drugs, other than inhalation drugs, administered through DME
J8498	Antiemetic drug, rectal/suppository, not otherwise specified
J8499	Prescription drug, oral, nonchemotherapeutic, NOS
J8597	Antiemetic drug, oral, not otherwise specified
J8999	Prescription drug, oral, nonchemotherapeutic, NOS
J9999	NOC, antineoplastic drug
Q3001	Radioelements for brachytherapy, any type, each
Q4082	Drug or biological, not otherwise classified, Part B drug competitive acquisition program (CAP)
Q4096	Injection, von Willebrand factor complex human, ristocetin cofactor (not otherwise specified), per I.U. VWF:RCO
S5000	Prescription drug, generic
S5001	Prescription drug, brand name

**These codes are subject to change pending routine updates.*

Please submit an NDC in the following fields:

- **Electronic professional claims:** 837P Loop 2410/Data Element LIN02 = N4 qualifier and Data Element LIN03 = NDC
  - Example: LIN**N4*00093723106~
- **Paper professional claims:** field 24A in the shaded area above the date of service.

  Report the N4 qualifier in the first two positions left-justified followed by the 11-digit NDC with no spaces in between.
  - Example:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER
N400026064871					

- **Electronic institutional claims:** 837I Loop 2410/Data Element LIN02 = N4 qualifier and Data Element LIN03 = NDC
  - Example: LIN**N4*00093723106~
- **Paper institutional claims:** box 43 (revenue code description)

  Report the N4 qualifier in the first two position left-justified followed by the 11-digit NDC with no spaces in between.
  - Example: N400093723106

If you have questions, please contact your Network Coordinator.

Antepartum care billing

Antepartum care is considered integral to global obstetrical care and may be reported separately only when a delivery is not provided. When *only* antepartum care is provided, the CPT® guidelines for billing these services should be followed. If you provided a total of fewer than 4 visits:

- First visit — bill 99201-99205 (New Patient Evaluation and Management [E&M] service) or 99211-99215 (Established Patient E&M service)
- Second and third visits — bill 99211-99215 (Established Patient E&M service) for each

The level of E&M code billed is determined by the key components of the service performed and documented in the medical record.

Most second and third visits typically require only a Level 3 office visit. Exclusively billing these visits at higher levels than medically necessary is not an appropriate billing practice and is subject to post-payment review.

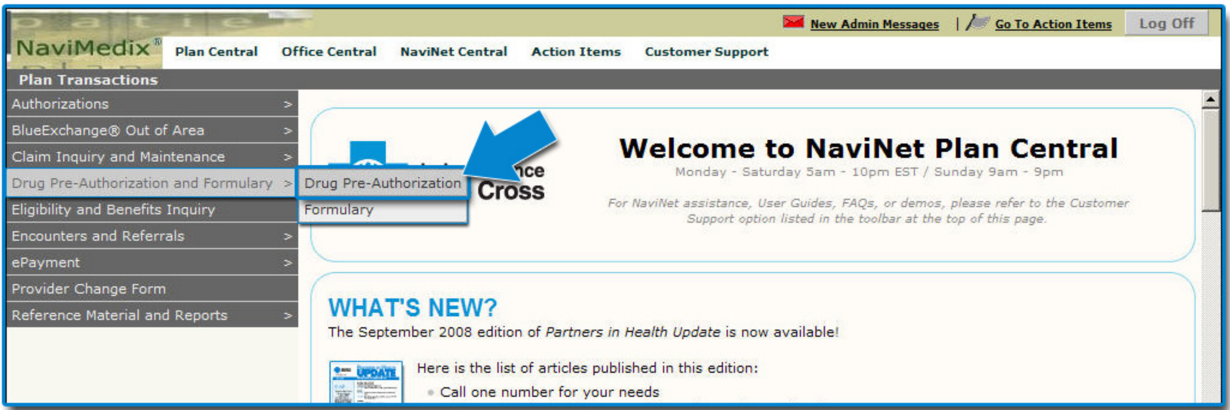
Should a patient change OB groups during her prenatal care, both providers should bill for the services they have rendered.

Drug Pre-Authorization on NaviNet

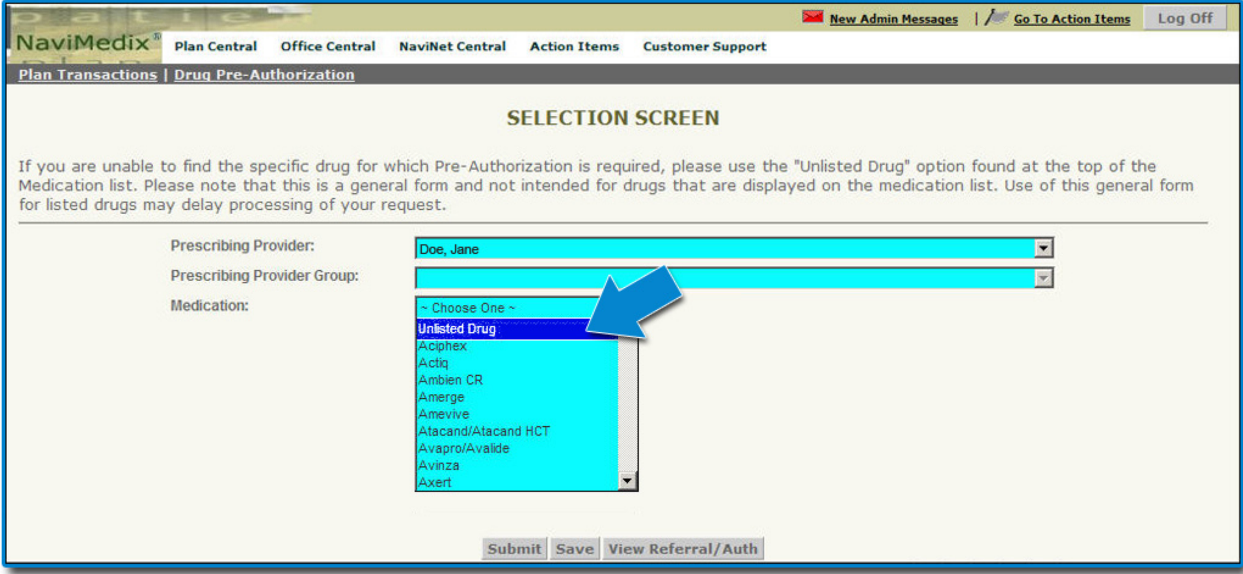
The *Drug Pre-Authorization* transaction on NaviNet has recently been updated. The entire list of drugs requiring preauthorization has been brought up to date and we've added new criteria questions to assist you in the submission process.

This transaction is used for both injectable and oral drugs that can be administered by either the member or family.

To preauthorize a drug for a member, select *Drug Pre-Authorization* from the list of available plan transactions, then complete the *Patient Search* screen by identifying the member's ID or name. Then select the appropriate drug from the medication drop-down list.



If you are unable to find the specific drug for which preauthorization is needed, please use the "Unlisted Drug" option found at the top of the medication list.



Several of these medications have a Direct Ship option, including Botox® and Supartz®.

Note: Preauthorization requests for injectable drugs that are administered as an infusion (either in a physician's office or as an outpatient) can be made by navigating to the *Chemotherapy/Infusion* transaction under *Authorizations* on Plan Central.

For assistance with these or any other transactions offered through NaviNet, providers should contact NaviNet Customer Care at 1-888-482-8057.

NaviNet® is a registered trademark of NaviMedix, Inc.

Select Advantage Private Fee-for-Service provider appeals

On January 1, 2008, we launched Select Advantage, a new Medicare Private Fee-for-Service (PFFS) plan. This Medicare Advantage PFFS plan is a non-network, non-managed care product that does not include utilization management or require referrals. However, all services must meet Original Medicare guidelines for coverage and are subject to retrospective review audit.

If a provider believes the payment amount received for a service (including the member cost-sharing collected) is less than what would have been received for the same service under Original Medicare, the provider may appeal the payment amount. To do so, the provider must submit to the plan reasonable documentation of the Original Medicare payment amount that applies to the service. For example, a remittance advice from a Medicare carrier would be considered documentation. All appeal requests should be submitted in writing and mailed to:

Provider Appeals
P.O. Box 37653
Philadelphia, PA 19101-0653

For questions about a general claim payment, please call our Customer Service department at 1-800-ASK-BLUE, prompt 2 for Provider Services, from 8 a.m. to 5 p.m. Monday through Friday. When calling, please have the following information available for the representative:

- Medicare provider billing number assigned by the Centers for Medicare & Medicaid Services;
- member's name;
- member's date of birth;
- member's Select Advantage PFFS number listed on the ID card;
- claim number in question;
- date of service;
- issue you want reviewed;
- additional information if necessary;
- copy of claim if available.

If the provider demonstrates that he or she has not received proper payment, Select Advantage PFFS will then pay the difference between what was originally received and what would have been received under Original Medicare.

A provider may file a standard appeal of a denied claim if he or she completes a waiver of liability statement that says he or she will not bill the member regardless of the outcome of the appeal.

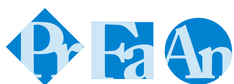
Appeals must be received within 180 days of the provider statement of remittance. Providers will receive a response to the appeal within 60 days, and providers must follow the provider and/or Medicare member appeal process depending on the nature of the issue. Applicable policies and procedures are available upon request.

If an out-of-area provider believes the amount he or she received for a service (including any member cost-sharing collected) is less than he or she would have received for the same service under Original Medicare, that provider may appeal the payment amount. Please contact the local Blue Plan's Provider Service department for further claims appeal information.

You can also visit our website at *www.ibx.com/providers.* Be sure to check future editions of *Partners in Health Update* for additional information on this new Medicare Advantage PFFS plan.

PRODUCTS

Keystone Direct Point-of-Service (POS): offering members more direct access to participating providers



The Keystone Direct POS benefits plan allows members to see most providers directly, *without a referral*. However, Direct POS requires primary care physician (PCP) referrals for routine radiology (except mammograms), physical/occupational therapy, spinal manipulations, and podiatry services. Obtaining a referral for these services ensures that the member receives the highest level of benefits. For laboratory services, members must obtain a laboratory requisition form from their PCP or specialist. For all other services, members may visit any Keystone network provider directly, *without a referral*. Utilizing providers who participate in the Keystone network ensures that members will receive the highest level of benefits and the lowest out-of-pocket costs.

Keystone's capitated program remains in effect for Direct POS. Similar to our Keystone HMO and POS benefits, PCPs must refer Direct POS members to capitated providers for capitated services (i.e., routine radiology, physical/occupational therapy, laboratory, and podiatry) for members to receive the highest level of benefits. Please note that mammography services are not capitated. Direct POS members may go anywhere in network for mammography under their benefits.

How the plan works:

- A Direct POS member selects a participating PCP from the Keystone Health Plan East network.
- No referrals are required for members to see participating specialists.
- Referrals are required for routine radiology (except mammograms), podiatry, spinal manipulation, and physical/occupational therapy services.
- A requisition form is required for laboratory services.
- The member is responsible for applicable cost-sharing.
- The member does not need to file claim forms when services are provided by participating specialists.

Note: For services requiring precertification through AIM (CT/CT scans, MRI/MRA, nuclear cardiology services, and PET scans), a separate PCP referral is not required. Additionally, referrals are never required for mammography.

BLUECARD®

Fall 2008 edition of *Inside IPP* now available

A new quarterly publication, *Inside IPP,* was introduced earlier this year. This publication is an Independence Blue Cross (IBC) initiative geared towards facility and ancillary providers to increase provider awareness of and satisfaction with the BlueCard® Program. The publication introduces new initiatives related to BlueCard processing and highlights plans for improvement.

The upcoming fall issue of *Inside IPP* features the following Medicare-related articles:

- Medicare Advantage overview
- FAQ for Medicare Advantage Private Fee-for-Service
- Medicare Advantage claims steps to follow
- Blues move to automatic crossover for all Medicare claims: All claims will be automatically submitted to the secondary payer
- Medicare-related claims: Present on Admission indicator for institutional billing
- Helpful Q&As and quick tips for filing claims
- Medicare secondary billing

The fall edition as well as past issues of *Inside IPP* are available at *www.ibx.com/providers/blue_card.* Paper copies of *Inside IPP* are available via the Provider Supply Line upon request.

All policy information now available on the web

In order to streamline our communications and better serve you, we are discontinuing the *Coding Guidelines and Policy Update (CGPU)* publication. Our website, *www.ibx.com/medpolicy* provides more up-to-date information on new and revised policies, as well as additional information to keep you informed. The fall 2008 version of *CGPU* is our last published issue.

You may now view all policy information on the Web eliminating the need to refer to multiple sources for administering and understanding the benefits of your patients.

The website includes:

- **Policy Bulletins.** Full listings of our medical and claim payment policies;
- **Policy Notifications.** A listing of new policy versions and their scheduled effective dates;
- **Recently Released Policies.** Current lists of new, updated, and archived policies;
- **News and Announcements.** Articles, updates, and information related to our policies.

For more details on these features, refer to the fall edition of *CGPU* and the *News and Announcements* section of *www.ibx.com/medpolicy.*

Policy notifications posted as of September 12, 2008

In order to better inform providers, Independence Blue Cross has developed a *Policy Notification* web page where our policies are posted prior to their effective date. Below is a listing of the policy notifications we have posted to the site as of September 12, 2008:

Policy Effective Date	Notification Title	Notification Issue Date
October 1, 2008	**08.00.75** Erythropoiesis Stimulating Agents (ESAs)	July 1, 2008
October 1, 2008	**06.02.01c** Lyme Disease: Diagnosis and Intravenous (IV) Antibiotic Treatment	July 3, 2008
October 1, 2008	**07.05.02f** Wireless Capsule Endoscopy (WCE)	August 29, 2008
October 21, 2008	**11.17.01d** Bulking Agents for the Treatment of Stress Urinary Incontinence (SUI) due to Intrinsic Sphincter Deficiency (ISD) and for the Treatment of Vesicoureteral Reflux (VUR)	July 23, 2008
November 1, 2008	**03.00.12** Modifier 78: Unplanned Return to the Operating/ Procedure Room by the Same Physician Following the Initial Procedure for a Related Procedure During the Postoperative Period	August 4, 2008
November 1, 2008	**03.00.31** Modifiers for Split or Shared Surgical Services (Modifiers 54, 55, and 56)	August 4, 2008
November 4, 2008	**05.00.61c** Cervical Traction for In-home Use	August 6, 2008

To access these notifications and view the policies in their entirety, follow these instructions:

1. Visit *www.ibx.com/medpolicy*
2. Select *Accept and Go to Medical Policy Online.*
3. Select the *Commercial and Other Medicare Advantage policies* link.
4. Select *Policy Notifications* from the Medical Policy column on the left sidebar.

Be sure to check back often as the site is updated frequently.

Announcing the Oncology Case Management program

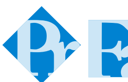
Our members benefit from having access to resources that help them to learn about and manage their health conditions. For this reason, Independence Blue Cross (IBC) is pleased to announce the development of a specific case management program to identify and reach out to members living with cancer. This case management program will be called Oncology Case Management.

The Oncology Case Management program is specially designed for people with cancer who are undergoing treatment. This program is designed to help them better understand and self-manage their condition through education and any additional support needed. Trained registered nurses will work with you and your staff to develop case management plans individualized to help your patients.

Oncology Case Management is a service that IBC provides to its members at no charge. Participation in the program is voluntary, and members may elect to not participate. Oncology Case Management will not interfere with your treatment plan or support for your patient.

If you are interested in referring any of your IBC patients to the Case Management department, please call 1-800-313-8628.

Incentives for UM decisions



It is our policy that all utilization review decisions are based on the appropriateness of health care services and supplies, in accordance with the benefits available under the member's coverage and our definition of medical necessity. Only physicians may make denials of coverage of health care services and supplies based on lack of medical necessity.

The nurses, medical directors, other professional providers, and independent medical consultants who perform utilization review services for us are not compensated or given incentives based on their coverage review decisions. Medical directors and nurses are salaried employees, and contracted external physicians and other professional consultants are compensated on a per-case-reviewed basis, regardless of the coverage determination. We do not specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage.

There are no financial incentives for such individuals that would encourage utilization review decisions that result in underutilization.

Transition to all-electronic inquiry and submission — Part II

Enhancements to the provider interactive voice response (IVR) system continue to progress. The new enhancements to the system will provide you with the ability to submit an authorization or precertification request for outpatient and office medical and/or surgical procedures.* This service will be directly accessible through Customer Service at 1-800-ASK-BLUE, prompt 2 for Provider Services.

This updated system will be available soon as part of our phased approach toward the electronic authorization mandate project.

Additional details as well as a tutorial will be available in future editions of *Partners in Health Update*.

**For behavioral health services, providers should still call the number listed on the member's ID card under Mental Health/Substance Abuse.*

Annual Synagis® (palivizumab) distribution program

This year Independence Blue Cross (IBC) has coordinated with FutureScripts® and ACRO Pharmaceutical Services, both independent companies, to be the sole vendor for Synagis® (palivizumab), during the 2008-2009 season. It is mandatory for all participating providers to obtain Synagis® (palivizumab) through the FutureScripts® Direct Ship vendor, whereby ACRO Pharmaceutical Services ships the agent directly to the physician.

In order to facilitate requests as efficiently as possible, all referrals should be sent directly to ACRO Pharmaceutical Services to coordinate shipment and the delivery of Synagis® (palivizumab) to your office. Do *not* forward referrals to MedImmune, LLC, as IBC is *not* participating in the RSV Connection™ Program.

ACRO Pharmaceutical Services will coordinate the distribution of Synagis® (palivizumab) with your office. Synagis® (palivizumab) can be ordered directly from ACRO Pharmaceutical Services by completing the RSV Enrollment Form. The form can be obtained by calling ACRO Pharmaceutical Services at 1-800-906-7798 or FutureScripts® Direct Ship 1-888-678-7012, option 3.

The following guidelines apply when ordering Synagis® (palivizumab):

- Synagis® (palivizumab) will generally be approved for office administration only, unless a patient is receiving home nursing services for a separate indication.
- The RSV enrollment form must include sufficient clinical information to meet the IBC Synagis® (palivizumab) medical policy criteria, which is based on recommendations from the American Academy of Pediatrics (AAP).
- Tobacco smoke will not be accepted as an environmental pollutant. This guideline is based on the AAP Committee on Infectious Diseases' indication that, while at-risk infants should never be exposed to tobacco smoke, passive household exposure to tobacco smoke has not been associated with an increased risk of RSV hospitalization on a consistent basis. (AAP 2006 Red Book, pp 563-565).
- Fee-for-service providers will be reimbursed for the evaluation and management procedure codes that correspond to the patient's office visit. You will not receive reimbursement for the actual pharmaceutical.
- Upon approval of your request, Synagis® (palivizumab) will be shipped to your office monthly during RSV season. Overnight shipping for the 2008-09 season will begin on Wednesday, October 29, 2008. Shipping will end on Wednesday, April 15, 2009. Up to five doses will be shipped per patient (one shipment every 30 days).

Precertification required for some Medicare Part B injectable drugs

Effective January 1, 2009, the following Medicare Part B injectable drugs require precertification:

- Aldurazyme®
- Aredia®
- Avastin®
- Boniva®
- Botox®
- Ceredase®
- Cerezyme®
- Elaprase®
- Eloxatin®
- Erbitux®
- Fabrazyme®
- Herceptin®
- Hyaluronan agents (injections), including:
  - Euflexxa™
  - Hyalgan®
  - Orthovisc®
  - Supartz®
  - Synvisc®
- IVIg®
- Myozyme®
- Orencia®
- Remicade®
- Rituxan®
- Synagis®
- Tysabri®

These Medicare Part B injectable drugs require precertification in an outpatient facility, a professional provider's office, or a home and must be precertified for all of the following managed care products:

- Keystone 65
- Keystone 65 Choice (POS)
- Keystone 65 Direct (POS)
- Keystone 65 Complete
- Personal Choice 65℠ (PPO)

For more information, please contact your Network Coordinator.

National Breast Cancer Awareness Month

The Centers for Disease Control and Prevention (CDC) recommend mammography screening as the best available method to detect breast cancer in its earliest, most treatable stage. However, according to a study published in the June 15 issue of *Cancer*, the proportion of U.S. women 40 and older who report having a mammogram in the previous two years declined from 70 percent to 66 percent from 2000 to 2005. The drop in mammography screening was most pronounced for women over 50.

Although the number of breast cancer cases has dropped in the past few years, this decline in mammography adherence may mean that some women with early-stage disease will not be diagnosed until later.

Independence Blue Cross (IBC) recognizes the importance of this screening. We have made mammograms more accessible to our members by:

- eliminating copayments, deductibles, and coinsurance for mammograms performed in-network;
- allowing members to go anywhere in the radiology network for screening and diagnostic mammograms*;
- enabling HMO members who require a follow-up breast ultrasound to receive the ultrasound at any participating radiology site. (*PA only*)

*All commercial and Medicare Advantage HMO members may obtain screening and/or diagnostic mammography, provided by an accredited in-network radiology provider, *without obtaining a referral*. HMO members must go to a participating radiology provider.

IBC offers the following resources:

- Breast cancer risk assessment tool. Based on the Gail model, this computer program developed by the National Cancer Institute estimates a woman's five-year and lifetime risk of developing breast cancer. Women identified as high-risk may be offered chemoprophylaxis against breast cancer. Find the tool on *www.ibx.com/providers* by selecting *Resources for Patient Management*, then selecting the *Internet Resources & Bulletins* link.
- Mammography screening reminder program. IBC mails mammography screening reminders annually to all female members ages 40 and older.
- IBC's member portal website, *www.ibxpress.com,* includes breast cancer information and email reminders to schedule a mammogram. (Members may register for a reminder from the American Cancer Society's "Once Is Not Enough" email program.)

Decision Support videos**

Five breast cancer videos are available on topics ranging from early-stage breast cancer to breast reconstruction. A complete listing of Decision Support videos and other Connections℠ Health Management Program information and tools can be found at *www.ibx.com/providers/resources/connections.html.*

Providers can call the Connections Program Provider Support Line at 1-866-866-4694 for information about the Connections Program or to refer members to the program.

**The Decision Support videos are available for members eligible for the Connections Health Management Program.

The following American Cancer Society programs are available on *www.cancer.org* or by calling 1-800-ACS-2345:

- "Reach to Recovery." Helping breast cancer patients cope with breast cancer for more than 30 years, this program matches a trained volunteer breast cancer survivor with a newly diagnosed person to offer support and hope.
- "Look Good...Feel Better." This free, community-based program teaches female cancer patients beauty techniques to help restore their appearance and self-image while they undergo radiation and chemotherapy treatments.

Improving Medicare members' health with SilverSneakers®

Independence Blue Cross is pleased to announce the positive response we've received from members regarding the SilverSneakers Fitness Program. Members are lowering their blood pressure and cholesterol levels, losing weight, and enjoying themselves in the process. We've had an overwhelmingly positive response to our signature SilverSneakers fitness classes in which members feel the instructors are knowledgeable, friendly, helpful, and fun.

This program is provided to members at no additional cost to their monthly premium. The program offers members a free fitness membership at any participating SilverSneakers or Silver Access location.

SilverSneakers participating locations offer individuals access to amenities such as treadmills, weights, and pools. Members can take advantage of the signature SilverSneakers classes taught by certified instructors at certain SilverSneakers locations. Classes can include SilverSneakers® – Muscular Strength & Range of Movement, SilverSneakers® – Cardio Circuit, SilverSneakers® Yoga Stretch, and SilverSplash®. Class offerings vary by location.

Enrollment is easy. Members simply choose a participating fitness center that is conveniently located, present their membership ID card at the front desk, and ask to join SilverSneakers or Silver Access. Members can then tour the facility and see all the amenities available to them as new SilverSneakers members.

To learn more about the SilverSneakers Fitness Program or to find a location convenient for your patients, please visit *www.ibx.com/providers.*

Note: *Security 65® and 65 Special members are not eligible for SilverSneakers.*

®SilverSneakers is a registered mark of Healthways Health Support, Inc., an independent company.

Connections℠ Health Management Programs: supporting our members, your patients

Connections℠ Health Management Program

Call the Provider Support Line at 1-866-866-4694 to refer a patient for Health Coaching with any of the following conditions:

- asthma
- diabetes
- heart failure
- chronic obstructive pulmonary disease (COPD)
- hypertension
- coronary heart disease (CHD)
- migraine

Health Coaches provide disease management and decision support for numerous health-related issues.

Connections℠ AccordantCare™ Program

Call the Connections AccordantCare Program at 1-866-398-8761 to refer a patient with any of the following diseases:

- seizure disorders
- rheumatoid arthritis
- multiple sclerosis
- Crohn's disease
- Parkinson's disease
- systemic lupus erythematosus (SLE)
- myasthenia gravis
- sickle cell disease
- cystic fibrosis
- hemophilia
- scleroderma
- polymyositis
- dermatomyositis
- chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)
- amyotrophic lateral sclerosis (ALS)
- Gaucher disease

Call our Care Management and Coordination department at 1-800-313-8628 to refer a patient with end-stage renal disease on outpatient dialysis.

Partners in Health Update is a publication of the Provider Communications department for the exchange of information and ideas among the IBC provider community. Suggestions are welcome.

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This is not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, Indemnity, etc.), and/or employer groups. Providers should call Provider Services, listed at right, for the member's applicable benefit information. Members should be instructed to call the Customer Service telephone number listed on their ID card.

Not all benefit plans use Magellan Behavioral Health, Inc. to administer behavioral health benefits. Please check the back of the member's ID card for the telephone number to contact for behavioral health services, if applicable.

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IMPORTANT RESOURCES

View our online provider directories on www.ibx.com

CARE MANAGEMENT AND COORDINATION Case Management	215-567-3570 1-800-313-8628*
Baby BluePrints®	215-241-2198 1-800-598-BABY (2229)*
Healthy Lifestyles℠ Keys to Wellness	215-567-3570 1-800-313-8628*
CONNECTIONS℠ HEALTH MANAGEMENT PROGRAMS Connections℠ Health Management Program Provider Support Line	1-866-866-4694
Connections℠ AccordantCare™ Program	1-866-398-8761
CORPORATE AND FINANCIAL INVESTIGATIONS DEPARTMENT Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.ibx.com/anti-fraud
CREDENTIALING Credentialing Hotline Credentialing Violation Hotline	www.ibx.com/credentials 215-988-6534 215-988-1413
CUSTOMER SERVICE (Policies/Procedures/Claims) HMO and PPO	1-800-ASK-BLUE, prompt 2 for Provider Services
eBUSINESS Help Desk	215-241-2305
FutureScripts® Prescription Drug Authorization Toll Free Fax	 1-888-678-7012 1-888-671-5285
Direct Ship Injectable Fax	1-888-678-7012 215-761-9165
Blood Glucose Meter Hotline	1-888-678-7012
FutureScripts® Secure Medicare Part D	1-888-678-7015
HEALTH RESOURCE CENTER Healthy Lifestyles℠	215-241-3367 1-800-ASK-BLUE*
Precertification	1-800-ASK-BLUE
NAVINET® PORTAL REGISTRATION	www.ibx.com/providers/navinet/index.html
PROVIDER MEDICAL POLICY WEB PAGE	www.ibx.com/medpolicy
PROVIDER PHARMACY WEB PAGE	www.ibx.com/provider_rx
PROVIDER SUPPLY LINE	1-800-858-4728

* Outside 215 area code

Visit our website: *www.ibx.com/providers/communications*